

Symbolic diseases and ‘mindbody’ co-emergence. A challenge for psychoneuroimmunology.

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Abstract

Introduction

Over the last century there have been many reports of physical diseases that appear to be a somatic representation of an individual patient’s personal meanings or ‘story.’ In some, the somatic representation appears to be highly symbolic (Abrahamson, 1948; Alexander, 1950, 1960; Broom, 1997, 2000, 2002, 2007; Chiozza, 1998a, 1998b; Deutsch, 1959; Gottlieb, 2003; Griffith and Griffith, 1994; Groddeck, 1928; Hay, 1982; McDougall, 1989). Interest in these phenomena peaked during the 1940-70 period (Gottlieb, 2003), particularly around the work of Franz Alexander (Alexander, 1950, 1960), which focused on a limited number of supposedly psychosomatic diseases, such as duodenal ulcer (Mirsky, 1958) and asthma (Knapp et al., 1970). In line with extant psychoanalytic theory, these diseases were characterised as somatic representations of core conflict states and psychological defensive repertoires generic to each disease state. But interest in this work receded because of: the excessive reductionism involved (Blumenfield and Strain, 2006); the increasing identification of physical mechanisms for these conditions; more recent modelling of psychosomatic disorders in terms of trauma, dissociation, developmental blocks, and neural activation bypassing cortical pathways and consciousness (Gottlieb, 2003); a general cultural movement away from positivist notions of meaning to post-modern narrative-making; and the enduring general and medical acceptance of dualistic concepts of mind and body relationships. The result is that ideas of symbolic diseases have little traction in either modern medicine or psychoneuroimmunology (Broom, 2007). But, the reports cannot simply be dismissed, and they have important implications for understanding the relations of all disease with the symbolic realm.

Symbolic Diseases

Symbolic diseases (SDs) occur when “*the organ system involved, and/or the pathological process, and/or the clinical phenomenology, appears to be particularly congruent with, or appropriate to, the patient’s subjective meanings or “story”, as ascertained from the patient’s language, life history, and behaviours*” (Broom, 2002). The contention here is that SDs require a non-dualistic understanding of human personhood, and this will be pursued below. Because Western medicine is pervaded by an assumption of duality of mind and body, SDs can be startling for modern physicians. The following examples have been detailed and discussed more fully in the reference to each case.

Georg Groddeck (Broom, 2007; Groddeck, 1928) reported a man with haemorrhagic retinitis who in childhood knocked the figure of Christ off a crucifix with a stone. His episodes of haemorrhage began years later when a blind man known in the town as a ‘blasphemer of God’ came into the shop in which the patient worked. Subsequent exacerbations were clearly triggered by further crucifix-associated events, and, once understood, they ceased.

A woman (Broom, 2007) developed the precancerous condition oral leukoplakia (complicated by multiple episodes of oral cancer) at age 33, the same age her dentist father was when he died by suicide. At age 55, it emerged in brief psychotherapy that she carried a profound shame for having supposedly caused his death, and dealing with this issue led to a rapid and 15 year remission of the condition.

A woman (Broom, 2007) developed very aggressive rheumatoid arthritis whilst in an enmeshed marital relationship and social context about which she used the following language: ‘in a bind’ ‘I can’t get moving,’ ‘captured,’ ‘tethered, enslaved,’ and, indeed, ‘crippled’ by being in the town in which she lived. Therapy addressing these issues has led to remission of 12 years.

A woman (Broom, 2007) was raped by a twin brother at age fifteen, the assault beginning with rough handling of her breasts and then forced vaginal penetration. Thirty five years later depression ensued after her church minister embraced her, and she realised he had an erection. During therapy she began to bleed from the uterus, and a hysterectomy was performed. Soon after, she started to bleed from the bladder, at times when her male employers were being brusque or dominating. No bladder or kidney abnormalities were found. As the original rape event was approached in therapy she started to bleed from both breasts, and again investigation found no sinister lesions.

An elderly woman (Broom, 2007) was referred for a second opinion for an extraordinary widespread inflammatory thickening of her skin (and had been given a diagnosis of ‘connective tissue disease’). It began when she fell over and injured herself in a shopping mall. In her description of this, she repeatedly and spontaneously said ‘I went into my shell.’ She eventually recovered when ‘I came out of my shell,’ and recommenced ordinary activities.

Psychoneuroimmunology (PNI) and individual meanings

For several decades PNI has been the accepted conceptual psychosomatic framework for understanding and researching inflammatory diseases (Heim et al., 2000). PNI focuses upon the interactions between the mind, brain, and immune system in health and disease (Ader and Cohen, 1975) including: the influence of emotionally negative as well as positive factors on immunity (Herbert and Cohen, 1993; Segerstrom, 2005; Zorrilla et al., 2001); the impact of stress on immune-related diseases (Kiecolt-Glaser et al., 2002); the effects of behavioural interventions on immune system parameters (Kiecolt-Glaser et al., 2002); and, in the reverse direction, the effects of immune activity on neural and endocrine processes, behaviour and experience (Dantzer and Kelley, 2007).

The SDs pose major issues for PNI. Although the case is strong for the existence of very active and complex mind/brain/immune system interactions (Ader and Cohen, 1975; Besedovsky and del Rey, 1991; Blalock, 1984), the data generally available are several steps removed from the emotionally-significant, individual-specific, ‘story’ elements seen in the SD cases cited above, and which appear to be crucial ‘players’ in the drama of SDs. PNI

studies have focused on the 'essentialised' (Rotov, 1991), clinician-centred data of diagnosis, and on various derivative, subjectivity constructs or abstractions such as anxiety, depression, stress, personality, wellness measures, or attachment styles. Accordingly, PNI studies have used group-oriented research methods such as cross-sectional and pre/post designs, standardized questionnaires, and highly controlled laboratory stress tests, based on data-averaging across probands, rather than focusing intensively on individuals and the nuanced pathophysiological changes occurring in relation to highly specific meanings data and individual physical disease onset and exacerbation or remission (Schubert, 2008; Schubert et al., 2003).

One of the problems is that other models, commonly accepted and used by PNI researchers, by their very nature exclude nuanced meanings data. For instance, whilst allowing for psychological as well as neural, endocrine and immune elements, both the 'stress' model (Selye, 1936) and the 'allostasis' model (McEwen and Stellar, 1993; Sterling and Eyer, 1988) are basically models of 'forces' (objective, biological, mechanistic) rather than of 'meanings' (subjective). In addition, PNI has largely been construed in linear terms along the lines of the X-Y-Z model of Elliott and Eisdorfer (Elliott and Eisdorfer, 1982), where X represents the stressor or triggering event, Y represents the mediating neuro-endocrino-immune mechanisms, and Z represents the disease manifestation and recognition. This linear modelling artificially divides X, Y, and Z from each other, and construes mind (X) as causing changes in the body (Z) via neuro-immunological pathways (Y). It seems unlikely that the information-bearing capacities of the immune (or endocrine) systems Y can carry the symbolic information required for a symbolic disorder (Z). It is possible that the peripheral nervous system, or some yet unrecognised information system, might act synchronously with the immune and endocrine systems to specify body site etc, such that Z can be recognised as carrying the symbolic. For example, there are at least grounds for this possibility in inflammatory skin conditions (Arck and Paus, 2006; Arck et al., 2006; Holland, 2003; Newman, 1982; Panconesi and Hautmann, 1996; Theoharides et al., 2004; Wright et al., 2005).

Thus, despite very strong empirical group-data evidence for associations between stress and immune function (Herbert and Cohen, 1993; Zorrilla et al., 2001), PNI has had minimal impact on patient treatment. The lack of data addressing the complexity of individual patient 'mindbody' scenarios constitutes an inherent deficit in clinical utility, which maintains the researcher-clinician gap and undermines pro-active 'mindbody' approaches to clinical conditions (Pachankis and Goldfried, 2007). The result is that despite much indicative general research data the biomedical paradigm remains dominant, and the practice of medicine remains dualistic, keeping the realm of patient subjectivity (especially in its relationships to the onset and perpetuation of disease) removed from the clinical consultation.

In this ethos, SDs are more or less inconceivable--the assumptions undergirding most psychosomatic clinical practice tend to rule them out. On the research side, there has been in recent times virtually no exploration of possible mechanisms for symbolic illness. Unless current PNI concepts are radically expanded they cannot accommodate SDs. The issue becomes whether PNI assumptions can be refreshed in such a way that the highly distinctive data of each patient's individual experience and history can be understood as relevant to PNI mechanisms and integrated into the clinical understanding of physical disease, and utilised both to explain the emergence of SDs, and to treat patients with SDs in a way that takes the highly specific patient material into consideration. We assert here that PNI can be refreshed if the proper conceptual relations between physicality and subjectivity are restored.

Psychoneuroimmunology and the subjective world

Within the predominantly dualistic Western medical framework the body, conceptually, is a living biomechanistic entity. Where the dualistic emphasis is 'hard', the mind component somehow *associates* with this entity. Where the dualism is 'soft,' the mind *emerges* from the biomechanistic entity, and commonly has the status of an epiphenomenon. Moreover, biomedical science privileges bodily explanations for human activity and behaviour to such an extent that psychosocial phenomena are often regarded as mere 'holding patterns' until neurophysiological understandings or brain processes are identified, which can then effectively explain them away (Foss, 1994; Foss and Rothenberg, 1987). PNI research reflects these emphases, with its focus upon brain-to-immune system interactions, and its relative ignoring of the context in which humans operate as humans – in effect ignoring human 'personhood' (Broom, 1997, 2002, 2007). Persons are constituted as much by interactions with social and physical environment as they are by internal biomechanistic processes (Bateson, 2002; Booth, 2004, 2007; Varela, 1987; Varela et al., 1991). The outcome has been a reductionist PNI model, which gives priority to internal biomechanistic processes and blinds clinicians to the role of the symbolic realm in disease and illness.

The supposed duality of body and mind is a duality of perspective, a consequence of 'gazing' (Foucault, 2003; Gallagher, 2000; Maturana, 1980) upon two dimensions of personhood: *physicality* and *subjectivity*. The physical dimension, the body, is a self-organising and self-generating system of physical components (organ systems, organs, cells, molecules etc), which operate in concert to maintain both a coherent structure, and a set of relationships with the biophysical environment. Study of these physical components and their changing relations reveals what happens *internally*, when the body as a whole changes its relationship to its environment i.e. changes its 'behaviour.' The internal structural changes (e.g. neural firing, immune activity, etc.) that correlate with particular behaviours are not the behaviours, nor do they explain them, because what is called human behaviour is enacted, recognised or perceived *between* a whole body and its context (Booth, 2007; Maturana et al., 1995; Maturana and Varela, 1987; Varela et al., 1974). Coordinated operation of bodily components is necessary for particular behaviours to arise, but behaviour is the observed changing relationship between the body and environment rather than the operation of those internal bodily components. (Maturana, 1980).

As behaviours happen, the network of components within the behaving body changes its structural interconnections and, as a consequence, the domain of future possible behaviours for that body changes too. Thus, bodies are *historical* systems where the moment-by-moment structure is a consequence of previous structures and of previous relationships to its environment (i.e. its past behaviour). Repetitive behaviours are associated with the reinforcing of particular structural pathways within the body to facilitate those behaviours in future – the bodily structure adapts and entrains itself to be prepared for a set of behaviours that have been 'useful' in the past (Bateson, 2002; Maturana, 1980; Varela, 1987). A simple example would be athletic training entailing increased muscular strength, aerobic capacity, and coordination, with a correlating improvement in sporting performance. It therefore makes no sense to gaze merely at internal changes within the body and ignore the data arising between the person-body and the environment, because in reality there is a flowing continuity and integration between the internal and the external, the organism and its environment, the individual and the 'other,' the material and the symbolic.

The symbolic realm of language and image is thus highly linked to internal structure. Returning to symbolic disorders, the ‘stories’ crucial to them entail meanings emerging in a person’s experience of and with the world. Thus SDs demand a PNI model with an encompassing view of personhood, in which human behaviour and symbolic processes, along with important shifts in bodily mechanisms, are crucial elements.

But even more is needed—mind and body dualism must be abandoned. The dimensions of personhood referred to as subjectivity, experience, mind, and meaning, are schematised in the symbolic modes of language and image, and thus have nominal, abstract, and explanatory elements. Languaging processes and image constructions are a means by which humans (or other living things) coordinate their living together, and are learned and shared by those operating within the extended human ‘space.’ One of the constructions each person learns is the notion of ‘myself,’ a particular viewpoint associated with the experience of living in and through one’s own particular physical body, and its relation to an environment that includes other humans. The very notion of ‘myself’ is dependent upon dividing the individual from the environment, and is a continual process of ‘minding,’ of explaining and making sense of experiences of ‘myself’ in relation to the world and others (Booth, 2004; Gallagher, 2000; Maturana et al., 1995; Maturana and Varela, 1987). These *myself/other* experiences, characterised by elements such as love, rejection, or abandonment, are central in the kinds of stories found in SDs.

It makes no sense to consider ‘mind’ and ‘body’ as separate entities or as operating in any dualistic sort of way. These terms are ‘objectifying’ categorical devices used to refer to observed and experienced dimensions of person-hood. There is constant dimensional reciprocity. Changes in physical structure (the *internal* aspect) associated with bodily behaviour (the *external* aspect) alter the way persons attend to, experience, and interpret the external aspect. These attentional and experiential changes, in turn, feedback into the structural networks of bodies, and ultimately modify the trajectory of future behaviours and explanations.

Thus, ‘mind’ and ‘body’ are historically-conditioned dimensions mutually reflecting and influencing one another’s function. Both refer to an aspect of the relationship maintained between a person and his or her context – ‘body’ referring to maintenance within a biophysical context, and mind referring to maintenance within a linguistic and symbolic context of explanation and meaning-making. Furthermore, living in language is a learned behaviour, and is conditioned by the history of the entity exhibiting that behaviour. This means that the ‘minding’ processes of a person are contingent upon the history of that person’s bodily development. For example, pre-lingual bodily experiences must therefore permeate a person’s post-lingual psychological development. The consequence for PNI is that it must embrace the internal and the external, the pathophysiological and the ‘story,’ the historical and the present.

Person-hood, as the manner in which humans live as humans, not only emerges from the mutually interpenetrative dimensions of physicality and subjectivity, but necessarily exists in cooperative domains of relationships with other people (family, work, leisure, society, culture, etc.) because it is here that the shared understandings and interpretations necessary for linguistic coordination are generated and played out. What persons observe in others, and in themselves, are constellations of bodily displays, behaviours, and language, that make sense through shared (and historically acquired) explanatory frameworks. In this sense, person-hood can be construed as a biopsychosocial repository and exhibition of meaningful

behaviours, displays and communicative signals that have salience and utility for an individual exhibiting them, or for the group with which that individual is identified. This is the context and venue generating the experiences, meanings, and stories of SDs and, indeed, all disease.

If PNI is brought into this broad, multidimensional, integrated, internal and external, perspective it becomes logical to expect that seminal patterns of behaviour, thought or explanation and the intimately related bodily mechanisms (immune responses and inflammation) and structure will coagulate into SDs, somatically representative of a person's life experience and relationships.

Obviously, the process of recognising either a physical disease diagnosis, involving a *pattern of symptoms, signs, and technological study results*, or an SD, involving a disease projecting a *pattern of meanings*, is enacted in the 'space' between the person and the clinician. A concept of PNI that embraces the whole of personhood envisages a clinician who engages in a whole person approach to illness, who includes both the 'internal' and 'external' as crucial dimensions of illness, and who holds the diagnosis (body) and the meanings (mind) dimensions together in the same clinical time/space. It is in this context that SDs entailing a marked congruence between the physical pattern of the bodily illness and the patient's 'story' are discerned. The question persists: can PNI be refreshed to the point of easily accommodating these SD phenomena? What other models are available to assist this accommodation?

Current models of somatic representation of the symbolic

Historically, the psychoanalytic notion of defence has exerted a powerful influence upon psychosomatic theory. A feeling, thought, or desire may be quite unacceptable to a person at a *conscious* level, and thus defences are developed to prevent either conscious awareness and/or direct interpersonal expression of them. As a corollary, an alternative route is taken by the person to express them. If that alternative route is a symbolic body representation, the result will be an SD. The waxing and waning of psychoanalytic ideas of symbolic disease have been reviewed elsewhere (Broom, 2010).

Another model, proposed by Bucci (Bucci, 1997, 2002), arises from developmental, psychological, and linguistic theory. For a variety of reasons, a person may not have developed an adequate capacity for expression of feelings, urges, and thoughts in the *symbolic non-verbal* (imagery) dimension, or in the *symbolic verbal* (language) dimension, and thus an alternative option is taken to express such intensities through the *sub-symbolic* dimension i.e. the body. This model emphasises dissociation and impaired development more than concepts of defence, though does not exclude defensiveness as an associated mechanism.

The psychoanalytic and Bucci models share some core assumptions. One is that 'the truth will out,' that there is a drive to express, implying, in addition, a relational element in which there is an 'other' who will notice and respond. Thus there is a drive to communicate, or reveal, or to be known by an 'other' in the extra-personal context. Both imply a 'pressure' metaphor – the pressure rises and eventually there must be some release. Another implicit idea is that of a 'natural' tendency to develop and heal. A patient has feelings, ideas, and urges that need expression but must not be expressed directly, or which cannot be satisfactorily expressed and/or resolved via symbolic non-verbal and verbal dimensions, and thus the body becomes a necessary alternative signalling system.

Whilst helpful at the psychotherapy end of clinical practice, neither model gives any clues as to how SDs come about in terms of pathophysiology. In addition, the psychoanalytic, Bucci, and XYZ models all assume degrees of linearity, from mind to body, or from mind/brain through the immune system to manifest disease. Again, the problem is expecting Y to carry the symbolic information apparent in Z (the interpersonal dimension in which disease and its context are recognised). This expectation may be likened to expecting the nature of a journey to be encoded in the mechanics of the vehicle undertaking that journey. The mechanics and connectivity with the body of the vehicle constrain the dimension of possible journeys, but do not determine or realise them, because journeys arise in the dimension of relations between the vehicle and its context. Symbolic diseases demand another way of conceptualising the relationships between ‘story’ and physical disease manifestation.

Mind and Body Co-emergence

A model of co-emergence of personal meaning and physicality gives a much more robust framework for SDs, and for PNI. This needs amplification. Persons are not just bodies, they are ‘subject-bodies’ (Shigenori, 1992). The conditions for adult physicality and subjectivity are present from the beginning of life. All persons, from conception, emerge in an ethos of meanings whether they are maternal, family, or cultural meanings. The bodily and the subjective aspects of personhood co-emerge, co-constructing and conditioning one another, within an organism that is unitary. All subjective phenomena, whether they be feelings, emotions, thoughts, imagery, or personal problem stories laden with symbolism (manifesting later perhaps as symbolic disorders), have deep roots extending back to the person’s beginnings, and co-emerging with the body. What happens to the person-as-body happens to the person-as-subject and vice versa (Ford, 2007; Kovecses, 2003; Lakoff and Johnson, 1999). In this concept of co-emergence of the dimensions of body and subjectivity, the dualistic, compartmentalised, linear-causal model is replaced with a model of a ‘whole’ in which the body and the subjectivity are integral, mirror one another, and can be seen as the other side of one another (Broom, 2007).

The focus must shift from bodies to persons who have multidimensionality and multi-potentiality (both physical and subjective) *from the beginning*. The embryo, the foetus, and the neonate, emerge within a world of meanings transacted in many relational frameworks: interpersonally with all proximate and significant ‘others,’ and more subtly with the community, the culture, the nation, and the species. The person emerges in a veritable swamp of interacting physical, relational and social influences and elements. At no stage is there such thing as a body independent of these influences. The influences may be direct or indirect, but are never absent. The story of *this* patient with *this* disorder began at the beginning. The organism is a ‘whole’ with multiple dimensions including both physicality and subjectivity

Models are just models. It is not that the psychoanalytic, Bucci, XYZ, and co-emergent models are mutually exclusive – all have utility, and in their own way express something of the nature of the organism. But the problem is that PNI, as conventionally used, has been aligned with XYZ rather than co-emergent modelling, the effect being a profound limiting of PNI’s capacity to make sense of the relationships between disease and meaning, essentially because clinicians, working implicitly from XYZ assumptions, cannot see how the symbolic realm can be projected to the body. A co-emergent model of disease actively entertains the mutual involvement of physicality and subjectivity, and it makes no sense to keep using

language inimical to this. For example, the traditional terms ‘functional’ and ‘organic’, a legacy of dualistic separation of mind and body have no place in co-emergent modelling.

To put it another way, PNI, when using an XYZ analysis, is a descriptor term for the interactions of the brain/immune system/endocrine system *as studied from a dividing observer perspective that assumes discontinuities*. The mediating immune pathways (the “I” in PNI modelling, the Y in XYZ modelling) *seen by an observer as a discrete and separated entity* cannot carry highly symbolic ‘story’ information on their own. Yet the idea that meaning may or may not be in Y, a ‘part’ of the system, is faulty arising from the observers’ dualistic and atomistic assumptions, and it is contrary to a more plausible co-emergent model where meanings arise in the behaviour of the whole. It is also wrong to think that X, Y, and Z should be *re-connected*. They are actually observed manifestations of a unitary system, i.e. never disconnected. They are simply observations of the system made from different perspectives or through different lenses or filters. Just as body and subjectivity are co-emergent and co-constructing at the beginning, so they remain.

In a co-emergent system, it is expected that meanings will be reflected in some way at all levels. It is true though that some elements in the whole are more observable than others, and therefore more communicative (from the perspective of the observer). Internal autoimmune (Y) processes are not automatically communications, especially to someone who has no technological capacity to detect them. But, then, unless one is both a willing observer and attending carefully, communications at X (language meanings) and Z (somatic symbolic disease) levels may remain undetected as well. In the case (cited above) of the woman with oral leukoplakia, the X level information is a remembered experience of being blamed for her father’s death. At the Y level the information may be various immune system changes reflecting this experience. At the Z level the information is observed white plaques in the mouth, and a story emerging between the patient and the clinician of a dentist father, his death by suicide at age 33, the onset of her oral disease at age 33, and an uncovering of her shame at having ‘caused’ his death (and more).

But this clumsy XYZ modelling still strains to divide. In the end, detecting meaning is a ‘global’ thing. What is this woman with leukoplakia and cancer saying exactly, what are the meanings emerging in her talk (X)? What is happening in her life (X)? What is going on inside the body (Y)? What can we see when we examine the body (Z)? What does it all add up to? What do the patient and the clinician, together (X), think is going on? Simply, physicality and subjectivity (including highly specific meaning) must occupy the same clinical time/space together and be accorded similar respect and value.

The importance of symbolic diseases

SDs are important because they point to vivid expressions of meaning in the body, demand a re-appraisal of disease assumptions, and open up clinical horizons not allowed by biomedical models. SDs indicate that meaning and its antecedents (experience) and the body are ‘somehow’ co-pervasive. The ‘somehow’ is a very important issue. SDs point to a multidimensional organism, in which consciousness and experience are implicit, interpenetrative, and potential, from the beginning. Thus meanings, in their gradual development and maturation, are co-continuous and co-constructive with the soma and its physiology from the beginning. More directly, SDs imply that organs develop in a swamp of communal meanings, and, in the reverse direction, meanings that develop are highly influenced by our structure and its functioning. The metaphorical nature of language, influenced so much by bodily functioning, is one example of this (Kovecses, 2003; Lakoff

and Johnson, 1999). Meaning is generated between persons, within communities and culture, is conveyed in multiple human dimensions including language and body, is dependent on brain and peripheral nervous system as well as other body systems for its full array, and pervades and influences the whole of a person's reality both internally and externally. Meaning and disease, in this framework, are inevitable 'bed-fellows.' Linked within the concept of co-emergence they point to the possibility for a role (large or small) for mind and meaning in any disease.

The question becomes therefore in any illness, how best to look for meanings in a particular case: through the body clinical manifestation (Z), the microscope or laboratory test (Y), or the story (X). For humans, language (X) remains the most powerful route for conveying meaning. Some persons will represent their meanings and 'stories' clearly in language, some in behaviour, some in the body, and some (maybe most) in multiple ways. The clinician needs to be able to access meanings at any level.

The fact that modern PNI theorists do not speak of SDs is likely to be due to a combination of residual dualistic assumptions, a preoccupation with body (Y) processes, and limiting the focus on subjectivity to general categories rather than the patient's unique meanings. Together, these result in SDs being continually invisible. But PNI can accommodate SDs if it shifts its theory to a thoroughly non-dualistic view of persons.

Psychotherapeutic frameworks make it easy to understand that as the clinician sits with a patient with a physical disease, and as the 'story' emerges, there is a powerful sense in which it is not only new, it is also archaic. It began a long time ago. But it appears fresh or novel between the person and the clinician. It is fresh for many reasons. The connection between the disease and the story has been silenced for years (as the person defends him/herself against primordial intensities), it has been silenced for centuries as post-Cartesian clinicians have divided subjectivity from the body, and it has been silenced relationally because those 'others' (parents, siblings etc) likewise could not hold the person in his/her experience.

Clinical implications of a 'refreshed' psychoneuroimmunology

What kind of clinical space opens up when a person presents with a physical disease to a clinician working from co-emergent perspective? A number of attitudes, activities, and skills can be outlined. The person is seen as a subject-body and multidimensional, and is invited to tell a meanings as well as a diagnosis 'story.' The person discovers her own story as she listens to her own words reflected in the external communal space between her and the clinician. They recognise meanings because they were born within similar swamps of meanings. The clinician consciously reverses the dividing trend of the post-Cartesian world, and allows a unitive world in which the relationships between physical and subjective dimensions may be ascertained. The clinician knows that disease has some kind of subjective dimension – it cannot be otherwise – and is comfortable with mixing physical and subjective dimensions. Finally, the clinician holds the reality that the patient and the clinician are re-enacting, in the clinical space, some of the patient's archaic interactions with 'others.'

Utilising such a framework, people commonly recover from illnesses unresponsive to biomedical treatments (Broom, 1991, 1997, 2007). Is it that in using a framework closer to reality, latent therapeutic and healing potentialities are freed up? Is it that a reductionistic, physicalist framework locks patients into limited potential for healing/recovery? A person-centred, multidimensional medicine encompassing diagnosis and meanings requires clinical capacities for hearing crucial meanings, for positive relational encounter with the patient, and

for engaging with the subjective dimensions (of patients' diseases) that are revealed as these capacities are exercised.

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